CMS Manual System

Pub. 100-20 One-Time Notification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 67 **Date: APRIL 2, 2004**

CHANGE REQUEST 3157

I. SUMMARY OF CHANGES: This CR contains the requirement for Carriers, DMERCs, FIs, and Full PSCs to encourage providers to submit medical records to the Comprehensive Error Rate Testing (CERT) contractor for use in the November 2004 Improper Medicare Fee-for-Service (FFS) Payments Report.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 30, 2004
***IMPLEMENTATION DATE:** April 30, 2004

II. CHANGES IN MANUAL INSTRUCTIONS: N/A
(R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE

***III. FUNDING:** These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

***Medicare contractors only**

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 67	Date: April 2, 2004	Change Request 3157

SUBJECT: Requirement for Carriers, Durable Medical Equipment Regional Carriers (DMERCs), Fiscal Intermediaries (FIs), and Full Program Safeguard Contractors (PSCs) to Encourage Providers to Submit Medical Records to the Comprehensive Error Rate Testing (CERT) Contractor for Use in the November 2004 Improper Medicare Fee-For-Service (FFS) Payments Report

I. GENERAL INFORMATION

A. Background: The CERT contractor reviews approximately 120,000 randomly selected claims and corresponding medical records (when available) each year. However, providers oftentimes fail to submit the requested medical records to the CERT contractor. These providers, known as non-responders, contribute significantly to the Medicare FFS error rate. In an effort to reduce the error rate, CMS is issuing this one-time notification (OTN) to require Carriers, DMERCS, FIs and full PSCs to contact the billing providers under their jurisdiction who were selected for the November 2004 report and have failed to respond to the CERT request for medical records and to encourage them to submit the needed record(s) to the CERT contractor. We believe that having ACs contact non-responding providers will help lower the error rate significantly. NOTE: The November 2004 report will contain error rates for claims submitted during calendar year (CY) 2003.

B. Policy: Beginning January 27, 2004, the CERT contractor will post AC claim identification information for providers that have not responded to the CERT contractor's requests for medical records for claims submitted from January 1, 2003 forward on the CERT Claims Status Website (www.psccert.org) on a weekly basis. Each week, the website will be updated to indicate whether the requested medical record has been received by the CERT contractor. Each AC:

- shall check the CERT Claims Status Website at www.psccert.org at least once a week,
- shall contact all providers who have failed to submit medical records within 30 days of a request and encourage them to submit the requested records to the CERT contractor (these providers are known as 'non-responders'),
- may contact any provider who has failed to submit medical records within 20 days of the CERT contractor's request and encourage them to submit the requested records to the CERT contractor (these providers are known as 'tardy providers'),
- shall NOT contact any provider selected for CERT review until 20 days after the CERT contractor's initial request for a medical record.

ACs shall not expend resources to contact non-responders for claims they submitted before January 1, 2003, with the exception of claims included in the Non-Responder Special Study for which separate instructions have been issued through a Joint Signature Memorandum (3/3/04). Although ACs must contact all non-responders, ACs shall prioritize communications by first contacting those providers who submitted high dollar claims and those who non-responded most frequently.

ACs must make at least one telephone contact to providers. Contacting providers requires speaking with an individual who has access to medical records for a given provider. CMS requires at least one phone contact with each provider because there is no way to ensure that a letter or fax will reach the correct recipient without such a contact. Thus, phone calls and visits to providers are perceived as more effective than sending letters or faxes, while a combination of tactics would be most effective. CMS does not require that ACs use nurses to make their contacts. ACs should use any level of staff they deem appropriate to make these calls.

When contacting the provider, if they agree to submit the medical records to the CERT contractor, the AC shall ask the provider to include the barcode sheet with the copy. If they no longer have the barcode sheet, the AC shall ask the provider to write the Claim Identification Number (CID) (which the AC shall provide them) on the top of the medical record. ACs shall inform providers that they may fax medical records to 804-864-9980. If providers wish to speak with someone at the CERT contractor, they can call 804-864-9940 to speak with a customer service representative.

ACs may – but are not required – to contact third party providers and encourage them to send the needed records to the CERT contractor.

ACs must refer recalcitrant providers with claims in question of $40 or more (based on Medicare final allowed amount) for an individual billing provider PIN to the regional OIG staff whose email addresses can be found in Exhibit C.

The $40 threshold is based on an aggregate dollar value of a claim for a non-responder. Contractors shall aggregate the Medicare final allowed amount of all 2003 claims from a non-respondent to determine if the $40 threshold has been met (from the CERT Claims Status Website). Recalcitrant means that the AC has contacted the provider (at least 20 days after the initial letter was sent) and received reply A/E1/E2/F/G/I (see exhibit A), and no record has been received by the CERT contractor within ten days of the OIG letter being sent by the CERT contractor or within 10 days of the last AC contact (whichever is later).

ACs must keep a log of each referral made using the spreadsheet sent to the CERT points of contact upon issuance of this OTN (see Exhibit B for content required). ACs shall track entry into the spreadsheet by claim (not by line item). In a few months, the ACs will enter this data directly into the CERT Claims Status Website. Exhibit A lists the types of replies into which the ACs should categorize each reply. Contractors shall use this spreadsheet to make the referrals to the OIG.

C. Provider Education: This OTN is a provider education requirement.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
1	ACs shall check the CERT Claims Status Website at www.psccert.org at least once a week.	ACs (Carriers, DMERCs, FIs) and full PSCs
2	ACs shall contact each provider who fails to submit medical records to the CERT contractor within 30 days of the initial CERT request.	ACs/full PSCs
3	ACs shall keep a log of the referrals they make to the OIG using the spreadsheet sent to the CERT points of contact upon issuance of this OTN (see Exhibit B for content required).	ACs/full PSCs
4	ACs shall refer recalcitrant providers who billed claims for $40 or more to the OIG by emailing the relevant regional OIG staff whose email address are provided in Exhibit C. ACs shall use the spreadsheet sent to the CERT points of contact upon issuance of this OTN (see Exhibit B for content required).	ACs/full PSCs
5	Contractors shall not contact any providers selected for CERT review until 20 days after the CERT contractor's initial request for a medical record.	ACs/Full PSCs

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: Carriers/DMERCs/FIs shall report the expense under LPET CAFM Code 24116. Carriers/DMERCs/FIs must report in the 'Remarks' field the dollars spent and the number of providers contacted. ACs shall not spend more than 10% or $10,000 (choosing the lesser of the two) of LPET budget on the activities outlined in this instruction. ACs shall adjust their LPET strategy to accommodate this work for 2004. You may request additional funding if required.

For full PSCs, the technical guidance in this OTN is not to be construed as a change, or intent to change, the scope of work under the contract. It is to be acted upon only if it falls within the general scope of the contract and sufficient funds are available. Your attention is directed to the contract, Section I, FAR 52.232.20, Limitation of Cost, and FAR 52.243-7, Notification of Changes.

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 30, 2004. **Implementation Date:** April 30, 2004. **Pre-Implementation Contact(s):** Stacey Stinson, 410-786-9513, sstinson2@cms.hhs.gov **Post-Implementation Contact(s):** Stacey Stinson, 410-786-9513, sstinson2@cms.hhs.gov	**These instructions shall be implemented within your current operating budget.**

Exhibit A

Types of Replies

A – Provider indicates they have or they will submit the requested medical record to the CERT contractor.

E1 – Provider indicates that another department within the provider is responsible for fulfilling documentation requests.

E2 – Provider indicates that a different provider – a third party – has the relevant medical record.

F – Provider indicates they have the medical record but refuse to provide it without payment for copying/mailing charges

G – Provider indicates they have the medical record but refuse to provide it for some other reason.

I – Other

Exhibit B

OIG Referral of Non Responding Providers

Referral #
Contractor Number
Billing Provider ID #
CID #
Date of referral to OIG
Dates of service
HCPCS/ Revenue Code
Cumulative $ value of claims from this billing provider ID
and date of AC phone calls to billing provider where this claim was discussed
and date of AC faxes to billing provider where this claim was mentioned
and date of AC letters to billing provider sent where this claim was mentioned
Type of Reply
If Type of Reply = "Other," briefly explain
If Type of Reply = E2, list the contact info for the third party
and date of AC phone calls to third party where this claim was discussed
and date of AC faxes to third party where this claim was mentioned
and date of AC letters sent to third party where this claim was mentioned
Type of Reply
If Type of Reply = "Other," briefly explain

Exhibit C. **Office Of Audit Services - Regions**

Region	Name	States	E-mail Address
I	Boston		
		Connecticut	PFURI@oig.hhs.gov
		New Hampshire	
		Maine	
		Rhode Island	
		Massachusetts	
		Vermont	
II	New York		PFURII@oig.hhs.gov
		New Jersey	
		New York	
		Puerto Rico	
		(Virgin Islands)	
III	Philadelphia		PFURIII@oig.hhs.gov
		District of Columbia	
		Virginia	
		Maryland	
		West Virginia	
		Pennsylvania	
IV	Atlanta		PFURIV@oig.hhs.gov
		Alabama/Cahaba	
		Georgia	
		Mississippi	
		Kentucky	
		South Carolina/Palmetto	
		Florida	
		Tennessee	
		North Carolina	
V	Chicago		PFURV@oig.hhs.gov
		Minnesota	
		Indiana	
		Illinois	
		Ohio	
		Michigan	
		Wisconsin	

VI	Dallas		PFURVI@oig.hhs.gov
		Arkansas	
		Oklahoma	
		Louisiana	
		Texas (THE)	
		New Mexico	
VII	Kansas City		PFURVII@oig.hhs.gov
		Colorado	
		Missouri	
		North Dakota	
		Wyoming	
		Iowa	
		Montana	
		South Dakota	
		Kansas	
		Nebraska	
		Utah	
IX	San Francisco		PFURIX@oig.hhs.gov
		Alaska	Provider Follow UP
		Hawaii	
		Oregon	
		Arizona	
		Idaho	
		Washington	
		California	
		Nevada	